SYPHILIS CASE REPORT

NORTH DAKOTA DEPARTMENT OF HEALTH
DIVISION OF DISEASE CONTROL
SFN 61082 (8-2016)

The North Dakota Department of Health (NDDoH) Division of Disease Control requires the following information to be reported on all syphilis cases. This form shall be used for all newly diagnosed syphilis cases.

Required Patient Demographic Information:

First Name	*Last Name*		*Date of Birth*	
Street Address	*City*	*State*	*ZIP Code*	*Telephone Number*
Gender: ☐ Male ☐ Female				
Race: ☐ American Indian/Alaskan Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian/Pacific Islander ☐ White ☐ Refused			*Ethnicity:* ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Refused	
Pregnancy Status: ☐ Not Pregnant ☐ Pregnant ☐ NA			If Pregnant, Due Date:	
Was case tested for HIV? ☐ Yes ☐ No	If Yes: Collection Date:		*Result*: ☐ Positive ☐ Negative	

Stage of Diagnosis

What is Patient's Diagnosed Stage of Syphilis?

- ☐ Primary Syphilis *(Characterized by the presence of one or more ulcerative lesions (e.g. chancre))*
- ☐ Secondary Syphilis *(Characterized by localized or diffuse mucocutaneous lesions (e.g. rash), often with generalized lymphadenopathy)*
- ☐ Early Syphilis *(No symptoms present, initial infection must have occurred within the previous 12 months)*
- ☐Latent Syphilis (*No symptoms present, initial infection must have occurred greater than 12 months previously)*

Current and Past Symptoms

Did the patient have or ever had any of the following symptoms:	Date of Onset	Observed By Healthcare Provider	Duration (# of Days)	Additional Description
Chancre ☐ No ☐ Yes	____/____/____	☐ No ☐ Yes		
Sore/Lesion ☐ No ☐ Yes	____/____/____	☐ No ☐ Yes		
Skin Rash ☐ No ☐ Yes	____/____/____	☐ No ☐ Yes		
Alopecia ☐ No ☐ Yes	____/____/____	☐ No ☐ Yes		
Swollen Lymph Nodes ☐ No ☐ Yes	____/____/____	☐ No ☐ Yes		
Condyloma lata ☐ No ☐ Yes	____/____/____	☐ No ☐ Yes		
Mucous Patches ☐ No ☐ Yes	____/____/____	☐ No ☐ Yes		
Other Symptoms:_____	____/____/____	☐ No ☐ Yes		

Provider Information

Diagnosing HealthCare Provider:	
Facility:	*Telephone Number:*

Which laboratory tests were performed?

(Note: Need both a non-treponemal and treponemal test to confirm syphilis)

Specimen Collection Date: ____/____/_____

Non-Treponemal Tests

- ☐ RPR or
- ☐ VDRL

} Titer: 1:

Treponemal Tests

- ☐ TP-PA
- ☐ FTA-ABS
- ☐ Trep EIA

} Reactive or Non-Reactive

Other

- ☐ CSF-VDRL
- ☐ Other

Titer: 1:

Please Indicate Patient's Treatment:

- ☐ Benzathine penicillin G 2.4 million units IM in a single dose
- ☐ Benzathine penicillin G 7.2 million units total, administered as 3 doses of 2.4 million units IM each at 1-week intervals
- ☐ Doxycycline, 100 mg PO BID * 14 days
- ☐ Doxycycline, 100 mg PO BID * 28 days
- ☐ Other _____
- ☐ Not Treated

Treatment Dates:

- First Dose: ___/___/___
- Second Dose: ___/___/___
- Third Dose: ___/___/___

Did the patient have or ever had any of the following Risk Factors?

Is the patient resident/staff of correctional facility?	☐ Yes ☐ No
Has patient used intravenous/injection drugs?	☐ Yes ☐ No
Has patient used non-injection drugs?	☐ Yes ☐ No
Has the patient had sex while high/intoxicated?	☐ Yes ☐ No
Has the patient had sex with an injection drug user?	☐ Yes ☐ No
Has the patient traded sex for drugs or money?	☐ Yes ☐ No
Has the patient had sex with an anonymous sex partner?	☐ Yes ☐ No
Has the patient ever met sexual partners on the internet?	☐ Yes ☐ No
Total number of sex partners in last 12 months	
a. Number of Female Partners	
b. Number of Male Partners	
How frequently does the patient use condoms during sex?	☐ Always ☐ Not that Often ☐ Never ☐ Most of Time

Syphilis Partner History **If there is more than one partner, report using additional Partner History Forms**

Obtain Partner History for, Primary: Past 90 Days from Symptom Onset; Secondary: 6 Months from Symptom Onset; Early Latent: Past 1 Year; Late Latent: Past 1 Year

Partner Name:		Date of Birth or Approximate Age:	
Address:	City:	State:	Telephone Number:
Date of First Exposure:		Frequency of Exposure:	
Date of Last Exposure:		Note for Exposure Dates: Include approximate dates if exact date unknown.	
Did confirmed case recall symptoms (i.e. lesions, rash, etc) on partner? ☐ Yes ☐ No			
If yes, describe partner symptoms (include date):			
Partner Specimen Collection Date:		Results:	
Partner Treatment:		Treatment Date:	

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Partner Treatment:		Treatment Date:	

Please Fax Completed Forms to 701.328.0355 . Questions Contact NDDoH at 701.328.2378.

Revised: 08/2016

NORTH DAKOTA DEPARTMENT of HEALTH